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Medical Care for Public Assistance Recipients

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Today we seem to be emerging from an era of emphasis upon specialization into a wholesome regard for the total well being of the individual. This is reflected not only in professional thinking but also in much of the recent legislation dealing with health and welfare.

The Social Security Amendments of 1950, contained in Public Law 734, are a case in point. As you know, this law makes more liberal provisions for the medical care of public assistance clients. It reflects a point of view which is shared by the American Medical Association, as well as by public health officials, and by all other groups concerned with improvement of the Nation's health. Summarized briefly, this viewpoint, now translated into law, is that health is an integral part of any program designed to promote the welfare of needy individuals; and that tax funds can and should be used to purchase medical care for those who do not have the means to purchase it for themselves.

This legislation is the most recent milestone on the long road we have traveled since the days when publicly supported health services consisted of only the most fundamental sanitation and communicable disease control programs; and when tax-supported medical care was limited to the almshouse and town welfare physician type of service.

Other milestones are the development, with Federal funds allotted to the States through the Public Health Service, of expanded programs for general health services, and for the control of venereal disease and tuberculosis; of new programs in heart, cancer, diabetes, and other chronic diseases; of mental health programs; and hospital construction and its concomitant development of standards for hospitalization.

Additional health programs in States and communities have been brought into being or expanded with funds appropriated to the Children's Bureau for maternal and child health and for crippled children. The program of physical rehabilitation established under

*Deputy Surgeon General, Public Health Service. Delivered before the Conference of State Public Welfare Directors, September 12, 1950, Washington, D. C.

the Borden-La Follette Act and administered by the Office of Vocational Rehabilitation, also part of the Federal Security Agency, represents another major health service.

Many of these programs differ in approach from the earlier public health services. In the past, concern for individual health, as related to public health programs, was expressed chiefly in terms of mass control measures, whereas now many of the publicly supported programs involve a large element of service to the individual. Added together, our current tax-supported programs provide essential diagnostic and treatment services for a significant proportion of our population, and include some individual services which are available to all citizens, regardless of their economic status. Tangible evidence of the magnitude of these programs is the fact that public agencies and institutions spend between 1 and 1.5 billion dollars annually on health services and medical care in the States and communities.[1]

If the people are to be adequately served and if tax funds are to be efficiently used, public agencies at every level must operate within the framework of a total program. They must see their particular function in the health field as a segment of the whole, recognizing their own strengths and limitations, and utilizing each other's services and competencies to the fullest advantage. Just as the needs of the individual cut across jurisdictional categories, so must the operations of the agencies that serve him.

Each new piece of health legislation has added to the urgency of our need to develop mechanisms for coordination and cooperation among public agencies involved in any aspect of health and medical services. Only through such coordination and cooperation can we utilize to the full existing resources, develop new resources, eliminate duplication of services, resolve inconsistencies and conflicts in policies. Public Law 734, which permits welfare agencies to take substantially more responsibility for the content of medical care programs for the indigent, makes the need for joint planning imperative.

What provisions can be made to assure that the care paid for by welfare agencies is of high quality? To what degree can the services these clients need be supplied by existing public programs? For the answer to such questions, welfare agencies are looking increasingly to their health agencies, and it is right that they should do so. In the last analysis, responsibility for public health is vested in the health department, and it should be expected to take the lead in building, so to speak, a master plan for the total health program of the State or community. No other public agency has the concentration of medical and health personnel who could qualify it for this task.

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[1] Census Bureau compilation of State expenditures for health (including Federal grants) and city expenditures (over 25,000 population) for 1948, and county expenditures for 1946 total 1.3 billion. Public assistance medical care in 1948 is estimated at 125 million.

The desirability of centralizing responsibility for the general oversight of all health matters has long been recognized by authorities in both the health and welfare fields. The American Public Welfare Association, as far back as 1938, was specific in its recommendations, stating "it is essential that the administration of all preventive and curative services provided directly by tax funds, as well as the administration of all payments from tax funds to nongovernmental medical agencies and practitioners be closely related and functionally coordinated." [2] More recently, in fact, on January 7 of this year, the American Public Welfare Association presented a resolution on this subject which was adopted by the six national organizations who form the Inter-Association Committee on Health.[3] The resolution stated in part "any provision to finance medical care for assistance recipients should permit the administration of the medical aspects of such care by public health departments and . . . such arrangements should have the support of these six organizations." With this unanimity of agreement, there can be no doubt about the necessity of health departments playing a major role in the development of tax-supported programs in which medical judgment and supervision are involved.

The question, therefore, is not *should* the health agency take leadership in setting up plans for carrying out the medical care provisions of Public Law 734, but *how* should it do so. The specific arrangements will inevitably vary from State to State and from community to community. This is to be expected and is desirable, because people, States, communities, economies, and societies differ. However, from past experience in tax-supported health and medical care programs, we already have some fundamental principles which we know can be applied to advantage in any area, regardless of local variations.

We know, for example, that if a program is to operate democratically with the enlightened support of its citizens, it must take into consideration the needs and opinions of the persons who use its services as well as of those who provide the services. And we know that this can be done only with the aid of citizens' advisory committees which are truly representative of both the users and providers of service. It seems to me that provision for such State and local advisory committees should be written into State plans. I consider the advisory committee absolutely essential in assuring that the policies under which the program operates will be in line with public needs. At present, very few States and localities have such committees, and where they do exist their membership and function are limited. Committees of physicians to negotiate fee schedules are probably the

[2] Organization and Administration of Tax-Supported Medical Care. Committee on Medical Care of the American Public Welfare Association, December 1939.

[3] American Dental Association, American Hospital Association, American Medical Association, American Nurses Association, American Public Health Association, and American Public Welfare Association.

most common. Committees dealing with such special technical or professional matters could more properly be established as special subcommittees to the general group which considers broad policies.

Corollary to the need for a citizens' advisory committee which will see the health program as a whole and make its recommendations accordingly, is the need for free channels of communication among the staffs of all governmental agencies that will be involved in carrying out such recommendations. An interdepartmental committee of State or local government officials helps meet this problem of communication. Such a committee would include representatives from all public agencies dealing with preventive or curative services in hospitals, clinics, and homes, or furnishing medical care to special groups such as children and the blind.

In the specific planning for implementing the medical care provisions of Public Law 734, some strengthening of relations between health and welfare agencies would seem to be indicated. The health officer might serve in an official advisory capacity to the welfare department. Or conversely, responsibility for administration of the medical care program might be delegated to the health department with the welfare department serving in an advisory capacity. This might be done locally, even where it is not feasible on a State-wide basis. Another possible method might be the assignment of health department personnel to the welfare department. If there is a medical staff in the welfare department, it should communicate with the health department. The medical officer, whether an employee of the health or welfare department, would have as his main responsibility the establishment of liaison between the two departments and the development of the closest possible working relationships between these two agencies and all other official, professional, and voluntary groups involved in the medical care program.

All of these organizational devices for obtaining cooperation among personnel and achieving coordination of services have been suggested by the American Public Welfare Association in the report which it submitted last fall to the Inter-Association Committee on Health.[4] And all of these devices have some measure of proved effectiveness in the operation of other health programs. The organizational devices used, however, are less important than the spirit and attitudes of those who use them. It is conceivable that an effective program might be developed without any formal provision for cooperation. If health and welfare staffs work closely and congenially together and consult spontaneously whenever they deal with interrelated problems, they will inevitably make plans together and define areas of responsibility for this program, just as they have for other programs in the

[4] Not published.

past. Ideally, of course, cooperative efforts should be carried on through both formal and informal channels.

Granting the necessity for cooperative endeavor, what are some of the immediate tasks to which it should be directed in order that Public Law 734 can mean improved health service for public assistance clients? Here again, no specific answers will hold valid in all areas. Alert health and welfare agencies will find their answers arising from their own local needs and situations. In fact, perhaps the greatest boon of the Social Security Amendments is that they will stimulate a fresh review of existing services. The health officer has information on all the public health and medical care programs supported by tax funds—not only those which are operated for the medically indigent, but also those which are available to all citizens, regardless of income. It is essential that the welfare agency know about and utilize these existing resources to the fullest extent and not duplicate them in setting up machinery for handling the medical care provision of Public Law 734. It is also important to eliminate conflicts and inconsistencies in existing programs. For example, in some areas, the health and welfare departments have different payment schedules for the same services, causing unnecessary confusion and difficulty in their relations with private physicians and other vendors of service. This is the time to set existing programs in order so that expanded services can be geared into them efficiently and economically.

During the course of program review and evaluation, the study of medical care programs in other jurisdictions may be helpful. The Bureau of Public Assistance, in 1946, conducted a comprehensive study in cooperation with 20 States. Special studies have also been made of the programs in the States of Washington and Maryland. In Maryland, the health department administers the present medical care program for the medically indigent. I would expect that, in States where such an arrangement exists or is initiated, funds for strengthening the program might be made available to the health department under the provisions of Public Law 734.

State and local enabling legislation will need review in order to determine whether the jurisdiction can receive the full benefit of the changes in the Federal law. Some States and local communities have restrictive provisions regarding type of service, eligibility of recipients, and responsibility for administration. Some States limit or even prohibit the transfer and administration of funds from one agency to another, even though the latter may be in a better position to give the service. Obviously, before any specific plans can be made, the legislation which would affect them needs to be examined.

Other issues that will need to be settled have already been outlined by the American Public Welfare Association. They include:

1. Definition of allowable medical expense items for which the State will accept financial responsibility.

2. Provisions governing patient's selection of physicians, dentists, and other vendors of health or medical services.

3. Fee schedules, hospital rates, contractual agreements, membership in prepayment plans, maximum limitations, and similar items governing payment. If a pooled fund is established, for example, how would it be set up and administered?

4. Method of authorizing service for purpose of reimbursement, reporting devices, and other necessary mechanics of administration.

5. Contractual arrangements with the public health departments, if the welfare agency wishes to undertake a cooperative administrative relationship with the health agency.

Each of these issues, and others, call for judgments and competencies which the health department can be expected to supply. Since all services covered by the State plan must be State-wide in scope, the State health officer's knowledge of the adequacy, or inadequacy, of local public health services throughout the State will be important. Health department data on incidence of illness and disability rates will also be of aid in estimating cost of services so that coverage, at the outset, can be geared to budget limitations and will not have to be curtailed later.

The health department should likewise be prepared to advise on safeguards to be thrown around provisions for prepayment plans. This is particularly important since many States will want to take advantage of the opportunity which Public Law 734 provides for participating in prepayment plans and since they have had little or no experience in using such plans.

Under Public Law 734, a State agency must be designated to be responsible for establishing and maintaining standards for public medical institutions and private institutions offering medical or domiciliary care to public assistance clients. It would seem logical that the hospital authority, which is usually the health department, should be the agency designated, since it already has responsibility for licensing hospitals and, in some instances, nursing homes. It would, however, be essential that the hospital authority consult with the welfare department in formulating policies for licensure. Although July 1, 1953, is the deadline date for the carrying out of this amendment, preliminary planning will need to be started almost immediately.

Both the health department and the vocational rehabilitation agency have a direct interest in the new category of clients covered by Public Law 734—the permanently and totally disabled. What machinery should be established for certification of eligibility? How shall medical need be determined? What rehabilitation services shall be

provided? Fortunately, health departments and vocational rehabilitation agencies have a fine record of cooperative relationships, at both State and local levels. Thus, many of the mechanisms for developing a coordinated program for clients in this category already exist.

With proper preparation and close cooperation among all concerned, I believe that the plans made for the administration of the Social Security Amendments can carry us forward to a higher standard of care for all medically indigent. For example, the investment which public agencies will now be making in direct payments for medical care for the aged places them in a strong position to change the present emphasis on palliative measures to one of real rehabilitation. The work which has been done by Dr. Murray Ferderber and his associates with patients in the Allegheny County, Pa., almshouse indicates what could be accomplished everywhere if real effort, ingenuity, and leadership were devoted to a program for restoring the aged and handicapped to a maximum degree of usefulness. Of 308 patients involved in Dr. Ferderber's intensive rehabilitation program, 80 percent recovered at least to the point of not being bedridden, and 28 percent were able to leave the institution.

Similarly, with the more liberal provisions for medical care for dependent children which Public Law 734 makes possible, standards could be established which would include preventive as well as curative services for children.

State health and welfare agencies are in a strategic position to play the major role in the progressive advancement of tax-supported health services. Their local counterparts, working with the same high degree of cooperation, might be even more influential if they were more adequately equipped and staffed. Unfortunately, many communities have not yet established full-time local health departments, and, consequently, cannot rely on a local health officer for leadership in the development of the health and medical care programs which are authorized under Public Law 734 and other recent health legislation. This makes the role of the State health department even more crucial, both in State-level planning and in stimulating the development of local health facilities. It will, therefore, be particularly important for State health officers to recognize their responsibilities in this field and to be prepared to give the State directors of welfare extensive cooperation and assistance.

We, in the Public Health Service, will do all within our power to assist the State health officers in fulfilling these responsibilities. Discussion of ways in which health departments can give leadership under Public Law 734 was, in fact, one of the major items on the agenda of the Surgeon General's Conference with the State and Territorial Health Officers held in October.

Here in Washington, the Commissioner of the Social Security

Administration and the Surgeon General of the Public Health Service have had several discussions about ways in which the Public Health Service can be of assistance both in advising the Social Security Administration and in stimulating State health departments to assist State welfare departments. The Surgeon General has recently appointed a staff committee representing the various units of the Public Health Service which are concerned with medical care programs, and this committee is working on ways of developing closer relationships with all other Federal agencies involved in such programs. The information which they compile and the policies which they recommend, as well as the liaison they maintain with other agencies, should prove valuable in strengthening all medical programs, including those affected by Public Law 734.

Cooperative assistance to the Social Security Administration on specific problems relating to Public Law 734 will be provided by the Office of the Surgeon General and the Division of State Grants. Personnel in that Division have had a great deal of experience in working with States on health matters, and the full resources of that unit will be used in providing assistance on both policy and operational measures.

To further facilitate the free flow of information and service between health and welfare personnel of the Federal Security Agency, one of our Public Health Service officers, who is an expert on total and permanent disability, has been loaned to the Social Security Administration to work on that aspect of the legislation. Members of the Public Health Service staff, including the unit that deals with States, also serve, together with representatives of the Bureau of Public Assistance, Children's Bureau, and Office of Vocational Rehabilitation, on a committee of the Social Security Administration which has been established to work out common principles which can be applied to carrying out the Social Security Amendments.

Through the Division of State Grants, material and other aids will be continuously supplied to medical directors in the regional offices. I am confident that they will work in close harmony with the regional representatives of the Social Security Administration so that States which request consultation or other services will receive the benefit of their joint endeavors. It might be very helpful for these two regional representatives to visit States together to facilitate the development of cooperative plans between State health and welfare departments.

All of us, in the health and welfare fields alike, are venturing into new territory as we search for ways of promoting a high level of physical and mental health among the indigent. The medical care provisions of Public Law 734 represent one more step toward this ultimate goal. How to use these provisions most effectively in the

interests of our citizens is the problem we all share. Some of the answers may be expected to come from Washington; some from cities and counties; some from the States. Pooling all these experiences, the day may come when basic policies and principles evolve that will help each of us to carry on our part of the job more effectively, providing the medically indigent with a quality of care immeasureably higher than they have received.

We cannot predict when that goal will be reached, but we can say with certainty that none of us can reach it alone. It can be attained only through the full operation of the teamwork principle. Every illness has a social component; every social dislocation, a health component. The unity of health and welfare problems demands teamwork between us, professionally as well as administratively. It also demands that we bring the public onto our team by giving them a responsible share in planning and policy making.

Wherever teamwork has been used, the rewards have been great. Conflicts are resolved; creative energies released. Harmony and spontaneity result and these are the only bases on which real progress in social action can be secured.

Medical Services and the Social Security Act Amendments of 1950

By SELMA J. MUSHKIN*

The Social Security Act Amendments of 1950 pave the way for considerable extension and expansion of medical care for the needy.[1] These amendments—approved by the President August 28, 1950—in addition to extending the coverage and liberalizing the benefits of the Federal old-age and survivors insurance system, make three major changes in the public assistance programs which will have an impact on medical services for assistance recipients.[2]

1. Federal grants may now be made to States with approved plans for assistance to the permanently and totally disabled, thus setting up a new categorical public assistance program.

2. Federal grants are authorized for direct payments for medical services to persons or institutions furnishing medical or remedial care to the needy who are aged, blind, permanently and totally disabled, or dependent children.

3. Federal aid is made available to finance payments to the aged, blind, or permanently and totally disabled recipients of public assistance who are patients in public medical institutions, other than institutions for mental diseases and tuberculosis. Under the amended provisions, States which make payments (for old-age assistance, aid to the blind, or aid to the permanently and totally disabled) to persons in public and private institutions are required, by July 1, 1953, to set up an agency or agencies to establish and maintain standards for these institutions.

Federal Grants for Aid to the Permanently and Totally Disabled

Extension of the Federal public assistance grant programs to the permanently and totally disabled grew out of Congressional discussion of Administration proposals to extend the social insurance system to cover disability insurance and to provide Federal aid for general assist-

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[1] Public Law 734, 81st Congress, introduced as H. R. 6000.

[2] The Social Security Act Amendments of 1950 also extend the Federal public assistance provisions to Puerto Rico and the Virgin Islands for the first time. The formula for Federal participation in public aid payments for these jurisdictions is different from that for States and Territories; and a ceiling is set by statute on the aggregate Federal grants that can be made in any fiscal year. Moreover, for these jurisdictions, there is no Federal participation in payments to the relative living with dependent children receiving aid.

ance. The Commissioner for Social Security, in presenting the recommendation for Federal funds for general assistance before the Ways and Means Committee, stated: "A serious gap in the public assistance program results from the limitation of Federal participation to public assistance for needy aged and blind persons and dependent children only. States and localities have attempted, with varying degrees of success, to provide aid to needy persons who do not fall within these groups. Although some States with relatively large financial resources are able to finance adequate programs of general public assistance, many States and a great many localities have such meager funds for general public assistance that needy persons applying for aid can get only the barest necessities, and sometimes not even that much."(*1*)

The Ways and Means Committee of the House of Representatives rejected the proposed Federal aid for general public assistance and advocated instead Federal grants to the States for assistance to permanently and totally disabled individuals who are in need. This new program, the Committee indicated in its report to the House of Representatives, would parallel and supplement the recommended social insurance protection against permanent and total disability for earners in employments covered by the insurance system, just as old-age assistance parallels and supplements old-age and survivors insurance. The report pointed out that the disability assistance program, furthermore, would help in providing more adequate assistance to this group of needy persons than is afforded under the general assistance program in which the Federal Government does not participate (*2*).

The Finance Committee in its report to the Senate rejected both insurance and assistance for the permanently and totally disabled and asked for further study of the problem of the disabled worker. In conference between House and Senate, the House recommendation for a fourth category of assistance to the needy who are permanently and totally disabled was agreed to and the Senate omission of the permanent and total disability insurance provision was accepted.

The legislation as passed by the Congress and approved by the President provides Federal grants to States with approved plans for aid to needy permanently and totally disabled individuals aged 18 or over. To be approved, the State assistance plan for this category of aid, as for the other categories set up under the Social Security Act of 1935, must meet certain general statutory standards. For example, the plan must be State-wide in operation and must provide for State financial participation and for administration or supervision of administration by a single State agency. The State plan must also provide opportunity for a fair hearing for those denied assistance and must limit the use of information about individual recipients to purposes directly connected with the administration of public assistance. The

State also must make such reports as are required by the Social Security Administration. Additional State plan requirements, established by statute, include provision for excluding permanent and total disability assistance to those receiving old-age assistance, aid to the blind, or aid to dependent children. Plans may not be approved if they impose citizenship requirements which disqualify any citizen of the United States, or if they impose residence restrictions more stringent than those permitted in the Federal act. The maximum residence restriction for approvable plans for permanent and total disability assistance is the same as that for plans for aid to the needy aged and blind, namely, 5 years during the 9 years immediately preceding the application for aid and continuous residence in the State for 1 year immediately preceding the application.

The Federal share of the cost of State assistance programs for needy persons who are permanently and totally disabled is determined by the formula that governs Federal aid for old-age assistance and aid to the blind. As in these two programs, the maximum payment to an individual on which the Federal share of payments is computed is $50 a month. Federal participation in payments up to this maximum is determined on the basis of three-fourths of the first $20 of the average monthly payment per recipient plus one-half of the remainder. Expenditures for administration are matched on the basis of $1 of Federal to $1 of State and local funds. Under the Social Security Act, the amount of the aggregate Federal grant to a State for assistance is determined by the amount spent by the State and its localities, within the maximum on individual payments. The Federal payment is thus an open-end grant with no set allotment to a State and with no ceiling on the aggregate amount payable to a State.

In July 1950, about 500,000 cases, representing about 1 million or so persons, received general public assistance under State and local programs, aggregating $22.7 million for the month. Initially, most individuals aided under the new permanent and total disability assistance program will probably be taken from the general assistance rolls and transferred to the new program. However, some additional persons not receiving general assistance will probably receive aid under the new Federal-State program, even in the initial phases.

The Social Security Act Amendments of 1950 authorize grants to States with approved plans beginning with the quarter starting October 1, 1950. Although in some States general assistance is now restricted to those who are unable to work, in many others the general assistance rolls include persons who are employable as well as those unable to work. The new Federal legislation will require formulation of State plans and, in some States, new legislation. Among the

problems which will require solution are the definition of disability for assistance purposes and the formulation of appropriate administrative mechanisms for determination of this eligibility factor and for review of medical findings. The Social Security Act Amendments of 1950 exclude aid to any individual who is an inmate of a public institution, except that Federal participation is available to persons who are patients in a public medical institution. The amendments, however, exclude aid to individuals who are patients in an institution for tuberculosis or mental diseases or who have been diagnosed as having tuberculosis or a psychosis and are patients in a medical institution as a result. In the development of State plans, it will be necessary to establish definite and effective policies with respect to each of these exclusions and to solve borderline problems which arise in the administration of aid to the permanently and totally disabled.

Administration of the new assistance category affords a unique opportunity to obtain additional information on prevalence and types of disability among the needy and to effect a cooperative and closer working relationship among the agencies of government concerned with disability. A tentative reporting procedure has been developed by the Bureau of Public Assistance of the Social Security Administration which, in addition to providing the necessary records of cases for effective administration of the program, will establish a basis for obtaining knowledge of the causes, duration, and disabling effects of impairments leading to a finding of permanent and total disability. Information will be obtained on the cause of the impairment (whether an employment injury, a congenital defect, or other cause); on the mobility of the individual, the medical care he requires and has received, his family status and living arrangements, his previous employment history, and any vocational rehabilitation services received; and on other detailed information on factors that affect the extent of the problem of permanent and total disability and methods of meeting the needs of the individual.

Arrangements are also being worked out for the cooperation of the welfare departments of the States and the State vocational rehabilitation and health agencies in the administration of the program. The long-range costs and effectiveness of the disability assistance program can be favorably affected by increasing the employability and self-reliance of persons on the assistance rolls. Rehabilitation of recipients under the assistance program should therefore encompass not only services leading to active participation in the labor market but also measures to promote productive activity in the home and to increase the ability of a seriously handicapped person to help himself. The Bureau of Public Assistance and the Office of Vocational Rehabilitation are urging the closest possible working relations between the two administrative agencies in order to maximize the services to individuals

eligible under the programs. The Public Health Service and the Social Security Administration also have established cooperative working arrangements, and Dr. Carl Rice of the Public Health Service is assisting the Bureau of Public Assistance in developing guides and administrative arrangements for the new program.

Federal Aid for Medical Care in Behalf of Assistance Recipients

Assistance under the Social Security Act of 1935 was defined as money payments to individuals—a definition considered essential to establish the concept of assistance as a basic right of the individual and to emphasize his right and responsibility to manage his own affairs in the community. In the administration of the Social Security Act, Federal financial participation was precluded for any individual payment if the State imposed any expressed or implied restrictions on the recipient's use of the money payment. Federal funds were available for medical care only to the extent that costs of medical-care items were included, with costs of other budgeted needs, in unrestricted money payments to individual recipients. This limitation seriously impaired the effectiveness of the assistance programs in dealing with the problem of medical care for the needy. The unpredictable individual impact of illness and its costs made it difficult for States to make an allowance for medical expenses in money payments. Moreover, Federal matching was denied on payments made directly to hospitals, physicians, or others who provided care or services to recipients of assistance. Nor were Federal funds available for expenditures incurred by the welfare agencies for direct payments on behalf of recipients under group health insurance arrangements.

For almost a decade the Social Security Administration had urged that the basic legislation be amended to permit Federal financial participation in direct payments to hospitals, physicians, and others who furnished medical services to assistance recipients. H. R. 2892, introduced in the 81st Congress by Representative Doughton at the request of the President provided, in effect, for a separate medical assistance program under which the Federal Government would participate in expenditures for medical services up to an average of $6 a month for assistance recipients aged 18 or over and $3 a month for assistance recipients under age 18 receiving money payments or medical assistance under State plans. In the substitute bill, H. R. 6000, reported by the Ways and Means Committee to the House of Representatives, Federal funds were authorized to aid in financing direct payments to medical practitioners and others supplying medical service, including direct payments toward prepayment

plans such as Blue Cross. A separate medical assistance program was not provided for in H. R. 6000; aid to the needy under the separate assistance programs was redefined to include payments on behalf of the assistance recipient for medical services. Furthermore, in contrast to the Administration's recommendations, the Ways and Means Committee proposed that direct payments to medical practitioners and other suppliers of medical services, when added to money payments to assistance recipients, should not exceed the maximum individual payments on which Federal aid is computed. The same medical care provision was accepted by the Senate Finance Committee and enacted by the Congress.

The Social Security Act Amendments of 1950 redefine assistance under each of the categorical programs to mean money payments to, or medical or remedial care on behalf of, assistance recipients. Beginning October 1, 1950, Federal aid became available for direct expenditures for medical care under approved State plans for assistance to the needy aged, blind, permanently and totally disabled, and dependent children. The costs of medical care may be included within the maximums on individual payments in which the Federal Government will participate. The agency may make money payments to assistance recipients, payments to vendors directly, or contributions to prepayment plans. Such prepayment arrangements may be effectuated by properly safeguarded trust funds within the welfare agencies, by contract arrangements with health departments or other public agencies, or by insurance with private prepayment organizations.

The Federal share of the medical care costs, within the maximum limitations on individual payments, under each public assistance program will be about half of the expenditures for medical care under the assistance programs in States with approved plans. Because of the specific Federal grant formulas in these programs, the exact proportion of expenditures financed from Federal funds, within the individual maximums, will differ from State to State, depending on the level of average payments under each of the Federal-State assistance programs. As indicated earlier, the Federal share of old-age assistance, aid to the blind, and aid to the permanently and totally disabled is three-fourths of the first $20 a month of average payments and one-half of the remainder within a maximum of $50 a month for any recipient. The Federal share of aid to dependent children is three-fourths of the first $12 of average monthly payments per person aided and one-half of the remainder within maximums of $27 a month for the first child and adult relative with whom the child lives and $18 a month for each additional child in the family. Thus, the Federal shares under old-age assistance, aid to the blind, and aid to the permanently and totally disabled are as follows:

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Average monthly payment *	*Federal funds*	
	Amount per recipient	*Percent of total*
$20	$15.00	75
25	17.50	70
30	20.00	67
35	22.50	64
40	25.00	62
45	27.50	61
50	30.00	60
60	30.00	50
70	30.00	43

*The average for Federal matching purposes includes all payments of $50 or less and, in case of larger payments, only the first $50.

For aid to dependent children, assuming a two-child family plus one adult, the Federal shares are:

Average monthly payments to the family *	*Federal funds*	
	Amount	*Percent of total*
$25	$18.75	75
35	26.25	75
45	31.50	70
55	36.50	66
75	45.00	60
90	45.00	50
110	45.00	41

*The average for Federal matching purposes includes all payments within the maximums for families of specified size and, in case of larger payments, the amount of such maximums.

As indicated in table 1, all States except Mississippi paid an average of more than $20 a month for old-age assistance in July 1950, hence any additional expenditures for medical care for the existing case load will be matched on the basis of $1 of Federal funds for $1 of State and local funds within the maximum on individual payments. However, States will receive no additional Federal aid for additional assistance expenditures on behalf of individuals already receiving the maximum. The chart indicates the percentage distribution of public assistance payments in September 1949 in relation to Federal matching maximums.

The availability of Federal funds for financing direct payments to physicians, hospitals, prepayment agencies, and others furnishing medical services and protection to assistance recipients affords an opportunity to the States to establish or improve their medical care programs for the approximately 5 million persons receiving aid under the Federal-State assistance programs. Moreover, Federal aid places upon the States responsibility for assuring that increasingly there will be uniformity among communities in the health services included under State assistance plans.

Before enactment of the Social Security Act Amendments of 1950,

Table 1. *Average monthly public assistance payments to recipients, by State, July 1950* [1]

State	Old-age assistance payments per recipient	Aid to dependent children payments per family	Aid to the blind payments per recipient
Total	[2] $43.55	[2] $70.15	[3] $45.80
Alabama	20.21	29.77	22.71
Arizona	48.64	75.38	60.95
Arkansas	25.96	41.99	30.82
California	70.69	109.39	82.62
Colorado	65.65	79.22	54.66
Connecticut	62.41	116.46	61.84
Delaware	28.71	71.91	44.12
District of Columbia	39.23	73.20	41.08
Florida	34.87	44.37	38.21
Georgia	23.47	46.71	27.94
Idaho	43.21	94.18	46.50
Illinois	42.35	91.35	45.81
Indiana	36.30	66.43	38.92
Iowa	49.55	[4] 77.89	[4] 57.28
Kansas	50.09	64.35	50.83
Kentucky	20.56	37.42	21.97
Louisiana	47.33	48.82	42.92
Maine	44.50	64.74	45.19
Maryland	37.24	77.54	40.72
Massachusetts	65.43	112.10	66.54
Michigan	46.97	88.14	51.03
Minnesota	49.69	91.83	56.54
Mississippi	19.32	27.12	26.42
Missouri	43.83	52.47	[5] 40.00
Montana	53.21	78.57	57.40
Nebraska	44.00	82.40	58.78
Nevada	54.10	[6]	[6]
New Hampshire	44.32	89.89	48.53
New Jersey	49.07	92.18	54.09
New Mexico	32.54	48.98	32.12
New York	51.74	100.84	57.93
North Carolina	22.20	43.51	34.03
North Dakota	48.70	99.04	47.52
Ohio	45.86	[7] 61.39	45.12
Oklahoma	45.37	45.33	46.96
Oregon	53.61	104.12	62.53
Pennsylvania	37.54	84.39	[8] 39.89
Rhode Island	46.66	87.47	53.48
South Carolina	20.70	26.79	25.15
South Dakota	39.26	63.54	35.42
Tennessee	31.19	48.43	38.16
Texas	33.63	42.85	38.01
Utah	44.86	84.76	49.22
Vermont	35.61	54.51	38.77
Virginia	21.58	46.78	29.46
Washington	65.25	95.49	77.58
West Virginia	27.20	55.51	31.00
Wisconsin	43.26	96.36	46.69
Wyoming	55.35	97.73	53.80

[1] For definition of terms see Social Security Bulletin, January 1948, pp. 24-26. All data subject to revision.

[2] Includes Alaska and Hawaii, which are not shown in table.

[3] Includes Hawaii, which is not shown in table; Alaska does not administer aid to the blind.

[4] Excludes cost of medical care, for which payments are made to recipients quarterly.

[5] Represents statutory monthly pension of $40 per recipient. Program administered without Federal participation.

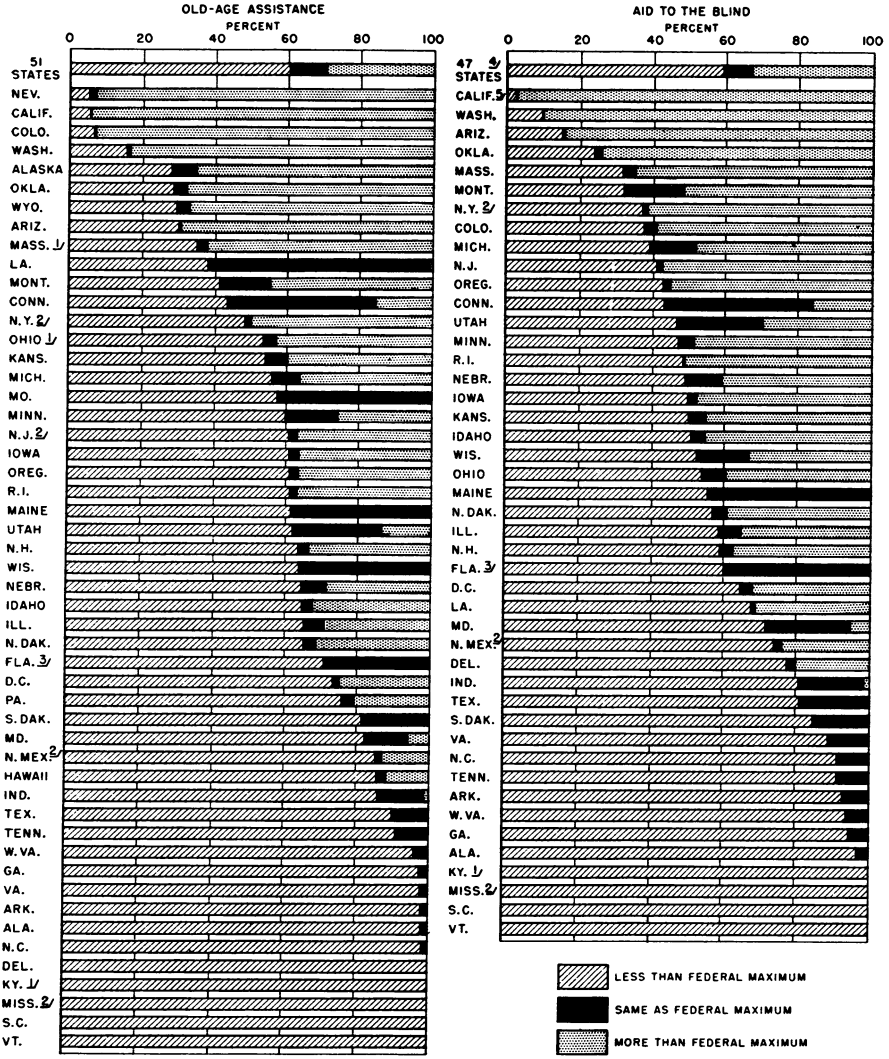
[6] Average payment not calculated on base of less than 50 cases.

[7] In addition to these payments from aid to dependent children funds, if supplemental payments from general assistance funds were included, the average payment would be $71.85.

[8] Program administered without Federal participation.

SOURCE: Bureau of Public Assistance, Social Security Administration.

PERCENTAGE DISTRIBUTION OF PUBLIC ASSISTANCE PAYMENTS IN RELATION TO FEDERAL MATCHING MAXIMUMS IN STATES WITH APPROVED PLANS, BY PROGRAM, SEPTEMBER 1949



[1] Data for December 1948.
[2] Data for August 1949.
[3] Data for October 1949.
[4] Total includes Wyoming and Hawaii with less than 100 recipients each.
[5] Excludes aid to the partially self-supporting blind.

many States met, from State and local assistance funds, the cost of medical care for public assistance recipients by payments directly to physicians, hospitals, or other individuals or institutions. In some of these States, medical costs for recipients of the special types of assistance under Federal-State programs were met from general assistance funds. In still others, State funds for the special programs were used. In Pennsylvania and West Virginia, all payments for medical services given to assistance recipients have been made directly to vendors. In a number of other States, vendor payments have been

made only for hospital expenses and other large bills. In a few States prepayment arrangements have been worked out for medical services to assistance recipients. In the State of Washington, physicians' services are provided through payment of $2.50 a month to the county medical service bureau for each person receiving assistance. In Kansas, in 1948, 27 of the 105 counties operated under medical insurance plans.

Great diversity has characterized the medical care plans for assistance recipients. The plans have run the entire gamut from the provision of comprehensive medical services available on a State-wide basis to separate local plans limited to physicians' services and drugs. A Bureau of Public Assistance study of welfare agency medical care plans in 42 States documents the wide variation in administrative practices and in financing.[3] Of the 42 States studied, only 8 had positions for a full-time medical director at the time of the survey (1946). Of these positions, two were vacant. Only 15 of the 42 States had general or technical advisory committees, and a number of these committees had not met within the preceding year. The memberships of the advisory committees that have been set up have usually been restricted and their functions limited to one phase of the program such as establishment of a fee schedule for physicians. Generally, in the States which make payments to physicians for services to assistance recipients, the recipient has free choice of practitioner. In others, city or county physicians are employed. Some States have standards of qualification for practitioners participating in the program, restricting those participating to physicians licensed to practice medicine and surgery. Diversity is found among the States, and often within States, in fees paid for medical services and in the basis for determining fees. Generally, fees paid are below the level prevailing in the community.

A recent study made in the Bureau of Public Assistance indicated that in the calendar year 1949 a total of about $125 million was spent by welfare agencies for medical care of the needy (*3*). Of this total, almost $85 million was spent for direct payments to physicians, hospitals, and others supplying services to assistance recipients toward which no Federal funds could be obtained. Although interstate comparisons are invalidated by differences in budgetary practices of the States, and differences in the degree to which cash and direct vendor payments are made, table 2 is of interest in illustrating the effect of medical care expenditures on the aggregate assistance payment per recipient. In four of the seven States,[4] spending an average of more than $4 per case for medical care on behalf of old-age assistance recipients, the total payment per recipient for cash assistance

[3] Unpublished data, Bureau of Public Assistance.

[4] Connecticut, Minnesota, Nebraska, New Hampshire, New York, Washington, and Wisconsin.

Table 2. *Special types of public assistance: Average monthly payments to recipients and monthly payments to vendors for medical services, by program, 23 States, 1949* [1]

State	Old-age assistance				Aid to dependent children				Aid to the blind			
	Total amount	Money payments to recipients	Payments to vendors for medical services		Total amount	Money payments to recipients	Payments to vendors for medical services		Total amount	Money payments to recipients	Payments to vendors for medical services	
			Average per recipient	As percent of money payments			Average per family	As percent of money payments			Average per recipient	As percent of money payments
Connecticut	$59.74	$55.49	$4.25	7.7	$106.98	$103.19	$3.79	3.7	$52.42	$50.71	$1.71	3.4
Delaware					72.99	72.42	.57	.8				
Illinois	47.27	43.76	3.51	8.0	100.22	98.62	1.60	1.6	48.51	45.86	2.65	5.8
Indiana	39.04	35.13	3.91	11.1	60.68	58.15	2.53	4.4	40.95	37.35	3.60	9.6
Kansas	49.52	47.40	2.12	4.5	88.09	83.14	4.95	6.0	52.20	49.52	2.68	5.4
Massachusetts	62.14	61.47	.67	1.1	114.70	113.35	1.35	1.2				
Minnesota	48.48	44.07	4.41	9.2								
Missouri	42.66	42.64	.02	(2)	53.54	53.47	.07	.1				
Nebraska	[3] 46.89	42.41	[3] 4.48	10.6	[3] 84.62	84.48	[3] .14	.2	[3] 51.30	51.07	[3] .23	.5
New Hampshire	48.01	43.31	4.70	10.9	96.38	87.34	9.04	10.4	50.65	46.29	4.36	9.4
New Jersey	47.60	47.55	.05	.1	86.99	84.11	2.88	3.4	52.18	52.16	.02	(2)
New Mexico	[3] 35.44	35.03	[3] .41	1.2	[3] 53.23	52.41	[3] .82	1.6	[3] 37.72	37.25	[3] .47	1.3
New York	58.08	53.42	4.66	8.7	113.54	108.63	4.91	4.5	64.08	59.94	4.14	6.9
North Dakota	47.95	46.49	1.46	3.1	99.14	98.68	.46	.5	47.43	47.18	.25	.5
Ohio	47.64	46.72	.92	2.0								
Oregon	51.76	49.53	2.23	4.5	104.81	101.93	2.88	2.8	58.33	56.13	2.20	3.9
Pennsylvania	41.58	40.00	1.58	4.0	94.44	91.81	2.63	2.9	40.85	39.92	.93	2.3
Rhode Island	46.03	44.94	1.09	2.4	87.64	85.51	2.13	2.5	51.50	50.90	.60	1.2
South Dakota	[3] 40.07	38.09	[3] 1.98	5.2	[3] 61.09	59.75	[3] 1.34	2.2	[3] 35.74	35.01	[3] .73	2.1
Virginia	20.34	20.30	.04	.2	44.37	44.25	.12	.3	27.80	27.76	.04	.1
Washington	[3] 74.17	66.84	[3] 7.33	11.0	[3] 150.28	135.58	[3] 14.70	10.8	[3] 85.44	78.04	[3] 7.40	9.5
West Virginia	25.33	24.21	1.12	4.6	49.92	48.39	1.53	3.2	28.89	27.81	1.08	3.9
Wisconsin	46.14	41.76	4.38	10.5	103.53	96.15	7.38	7.7	49.05	45.34	3.71	8.2

[1] Data not available for all programs for each of the 23 States.
[2] Less than 0.05 percent.
[3] Some expenditures from general assistance or other funds, not allocated by program, may be chargeable to these cases; amounts probably small except in Washington.

SOURCE: White, Ruth: Vendor payments for medical assistance. Social Security Bulletin 13: 4, June 1950.

and medical care was less than the $50 a month maximum. Even in these States, however, many aged persons were receiving cash assistance of $50 a month or more (see chart).

Initially, it may be anticipated that States with existing programs of medical care for the special groups of assistance recipients will be among the first to submit amended plans including provision for direct payment to physicians, hospitals, and others supplying medical services. Approximately half of the 37 States reporting information on vendor payments for medical services spent more than $1 million for these payments in 1949 (table 3), and 9 of these States reported expenditures in excess of $4 million each. Within the limitation of the maximums on individual payments and the exclusion of general assistance cases, at least part of these expenditures may become subject to Federal financial participation under the Social Security Act Amendments of 1950, provided the medical care provision is incorporated in an approved State plan. Furthermore, individuals who now receive general assistance for medical care only may be expected in the future, in increasing numbers, to receive aid under the special Federal-State assistance programs as they apply for and are found eligible under these programs. Provision of Federal aid toward payments for medical care thus presents a challenge to the various groups and agencies concerned with medical services for the needy to coordinate and expand these services.

There is widespread recognition of the problems posed by the variety of separate programs administered by different agencies which provide some health services to those in need and by the wide regional differences in the services available. Approximately $1 billion was spent by States and localities in the fiscal year 1949 for hospitalization and medical care; the largest portion of these expenditures was for hospitalization (*4*). In addition to public hospital facilities, wide varieties of diagnostic and therapeutic services are available through State and local health departments. In only one State, Maryland, has the State health department been charged with the administration of a State-wide program of medical care for public assistance recipients and the medically indigent. Health departments in some of the major cities of the Nation have major responsibility for general medical services for the needy. A recent study by Milton Terris and Nathan Kramer for the American Public Health Association shows that 66 local health departments have programs involving general medical care; 63 of these programs provide physicians' services and 20 provide general hospitalization (*5*). By and large, however, State welfare departments have carried the major responsibility for medical care, especially in providing physician, dentist, and pharmacist services to assistance recipients.

The need for coordination of effort has long been recognized by

Table 3. *Vendor payments for medical services, by type of case receiving services, 37 States, 1949*

State	Total vendor payments	Payments on behalf of recipients of						All other payments [3]
		Old-age assistance [1]	Aid to dependent children [1]	Aid to the blind [1]	General assistance and medical care only [2]			
					Total [1]	General assistance	Medical care only	
Total, 37 States	$80,771,571	$35,441,012	$10,170,011	$841,823	$16,278,622			$18,040,103
Alabama	10,262	4,388	2,013	147				3,714
Arkansas	198,305							198,305
Colorado	1,125,524	214,128	103,768	1,420				806,208
Connecticut	2,409,422	874,385	162,980	3,831	[4] 1,368,226			
Delaware	3,574		3,574					
Hawaii	513,987							513,987
Illinois	9,680,015	5,346,727	478,710	144,428	3,710,150			
Indiana	4,305,508	2,351,914	286,314	79,802	1,587,478			
Iowa	1,424,998		107,996	26,763	[5] 498,467			791,772
Kansas	2,139,685	950,382	307,815	24,780	839,660			17,048
Louisiana [6]	11,688	59	6,580	522	4,527	$4,389	$138	
Maine	939,174							939,174
Massachusetts	2,563,935	760,305	190,122		1,613,508	1,613,508		
Michigan	5,285,248							5,285,248
Minnesota	4,518,261	2,919,451						1,598,810
Missouri	81,792	30,430	18,754		32,608	12,997	19,611	
Montana	1,103,728	396,710	44,214	13,266	187,513	44,820	142,693	462,025
Nebraska	1,451,118	1,279,204	5,505	1,587				164,822
Nevada	587,109							587,109
New Hampshire	572,596	401,758	154,338	16,500				
New Jersey	1,169,495	15,155	176,406	126	135,696	135,696		842,112
New Mexico	199,870	46,320	48,643	2,526	73,096	44,056	29,040	29,285
New York	9,847,961	6,533,042	3,126,979	187,940	(7)			
North Carolina	1,025,173							1,025,173
North Dakota	374,847	154,054	9,420	355	211,018			
Ohio	6,126,520	1,387,690	287,465	16,507				4,434,858
Oregon	1,495,050	615,325	110,564	10,204	758,957			
Pennsylvania	4,505,000	1,682,000	1,509,000	171,000	1,143,000	1,143,000		
Rhode Island	455,516	127,757	84,357	1,126	242,276	234,297	7,979	
South Carolina	63,548							63,548

South Dakota	542,951	284,296	32,307	1,830	198,774			25,744
Utah	556	106	200		250	250		
Virginia	49,168	9,234	9,353	635	29,946	5,118	24,828	
Washington [3]	10,727,517	6,060,986	1,913,871	64,363	2,688,297			
West Virginia	760,363	320,977	243,319	11,824	184,243	70,898	113,345	
Wisconsin	4,171,510	2,608,550	732,604	59,424	770,932			
Wyoming	330,597	65,679	12,840	917				251,161

[1] Data incomplete for some States; amounts not distributed by type of case included in "all other payments."

[2] For some States, expenditures for cases receiving general assistance and those receiving medical care only not reported separately.

[3] In most States includes payments, not distributed by type of case, made on behalf of recipients of the special types of public assistance, general assistance, and medical care only, usually from general assistance funds; no expenditures made from these funds for old-age assistance cases in Ohio, or for old-age assistance and aid to dependent children cases in New Jersey. In Minnesota expenditures from these funds for old-age assistance cases were probably very small.

[4] Includes costs of burials.

[5] A small amount of these expenditures chargeable to the special types of public assistance.

[6] For 6-month period, July–December 1949.

[7] Expenditures for medical services ($1,991,436) include both money payments to recipients and payments to vendors; data on distribution by method of payment not available.

[8] For January–June, excludes cost of operation of county medical institutions; part of this cost—possibly $1 million—was chargeable to recipients of assistance, including cases receiving medical care only.

SOURCE: White, Ruth: Vendor payments for medical assistance. Social Security Bulletin 13: 7, June 1950.

authorities in both the health and welfare fields. By incorporation of health services available exclusively to the needy in State assistance plans, by formal budgetary arrangements through welfare departments, as well as by compliance with other State assistance plan requirements of the Social Security Act Amendments of 1950, Federal aid may be obtained to help States expand medical services to the needy. Professional groups representing physicians, dentists, nurses, hospitals, public health workers, and social workers have urged administration of the medical care aspects of such programs by the health departments, through interagency contracts.

Federal Aid for Assistance Recipients in Public Medical Institutions

Closely related to the problem of medical care for assistance recipients is that of institutional care for these groups. To prevent the continuance of poorhouses and perhaps even multiplication of these institutions with Federal financial support, the Social Security Act of 1935 prohibited Federal participation in payments to persons in public institutions, except to persons receiving medical care for a temporary period in public institutions. The Federal Government could participate in payments to the needy aged and needy blind requiring long-term medical care only if they resided in private institutions. It soon became apparent that modification was needed in the basic legislation. Jane Hoey, Director of the Bureau of Public Assistance, in testifying before the Ways and Means Committee of the House of Representatives on the Social Security Act Amendments, stated: "Many of the aged and blind recipients need long-time care in medical institutions. Private medical facilities cannot begin to care for all the people needing this type of care. The provision in the act barring the use of Federal funds for persons living in public institutions was intended to wipe out indiscriminate care in the old-time almshouse. Its effect has been to foster the development of commercial nursing and convalescent homes. Often these homes, which are operated for profit, are unlicensed and unsupervised and give very inferior care" (*6*).

The Social Security Act Amendments of 1950 make available Federal aid to finance payments to the aged, blind, and permanently and totally disabled recipients of assistance who are patients in public medical institutions, other than institutions for tuberculosis and mental diseases. Effective July 1, 1952, Federal financial participation is prohibited in payments to individuals in private institutions for tuberculosis and mental diseases and to an individual who has been diagnosed as having tuberculosis or a psychosis and who is a patient in a medical institution as a result thereof.

Under the amended provisions, existing public medical facilities can admit recipients of public assistance in need of long-term care without having the entire financial burden rest on the local community. Moreover, as indicated by the Finance Committee (*7*) in reporting the bill to the Senate: "If State-Federal old-age assistance is payable as would be provided by the bill to needy aged and to needy blind persons residing in public medical institutions, it is probable that many communities would develop additional facilities for chronically ill persons and thereby assist in meeting the increasing need for such facilities." Federal aid to mental and tuberculous patients in public medical institutions was excluded because of the nature of the illness, the large additional costs involved, and the prevalence of State hospital facilities for these patients.

As a necessary adjunct to the authorization for Federal participation in assistance to patients in public medical institutions, other than institutions for tuberculosis or mental diseases, the amendments require that an appropriate State authority (or authorities) be responsible for licensing and inspecting institutions to assure that their operation is in accord with standards established by the State. The Social Security Act Amendments of 1950 provide that, effective July 1, 1953, if a State plan for old-age assistance, aid to the blind, and aid to the permanently and totally disabled includes payments to individuals in private or public institutions, the plan must provide for the establishment or designation of a State authority or authorities which shall be responsible for establishing and maintaining standards for such institutions. As indicated in the report (*8*) of the Ways and Means Committee: "Persons who live in institutions, including nursing and convalescent homes, should be assured a reasonable standard of care and be protected against fire hazards, unsanitary conditions, and overcrowding."

A fairly good foundation already exists for the administration of this provision. A majority of the States have established comprehensive standards for licensure of hospitals and other institutions providing hospital and related care. All the States have established standards of hospital maintenance and operation for hospitals receiving Federal aid under the Hospital Survey and Construction Act; typically the licensing agency is the State health department. The need for interagency working arrangements has been indicated elsewhere in this issue. It is patently desirable to have a single standard-setting authority for medical institutions within each State and to utilize existing experience and machinery.

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(3) White, Ruth: Vendor payments for medical assistance. Soc. Sec. Bull. **13**: 3–7, 10, 28, June 1950.
(4) Expenditures for civilian social security and related public programs. Soc. Sec. Bull. **13**: 15–17, July 1950.
(5) Terris, Milton and Kramer, Nathan A.: Medical care activities of full-time health departments. Am. J. Pub. Health **39**: 1129–1135 (1949).
(6) U. S. Congress. House. Committee on Ways and Means: Hearings on H. R. 2892 (81st Cong., 1st Sess.). Part 1. Public assistance and public welfare. Washington, D. C., U. S. Government Printing Office, 1949, p. 400.
(7) U. S. Congress. Senate. Committee on Finance: Social Security Act Amendments of 1950. Report No. 1669 (81st Cong., 2d Sess.). Washington, D. C., Government Printing Office, 1950, p. 58.
(8) U. S. Congress. House. Committee on Ways and Means: Hearings on H. R. 2892 (81st Cong., 1st Sess.). Part 1. Public assistance and public welfare. Washington, D. C., U. S. Government Printing Office, 1949, p. 43.

Civil Defense Health Service Planning

The full facilities of the Public Health Service are available to the States in the development of medical civil defense plans, Surgeon General Leonard A. Scheele told health directors of the States and Territories in a letter of January 4, 1951.

Referring to the recently issued manual, Health Services and Special Weapons Defense, Dr. Scheele pointed out that "the Federal Civil Defense Administration has recognized the important part the State health officers can play in civil defense." He reminded the State health officers that the Federal Civil Defense Administration has asked that the regional offices of the Federal Security Agency and the Public Health Service regional medical directors provide assistance to the States in formulating, revising, and maintaining civil defense health service plans.

"I want to assure you on my own behalf and that of the Public Health Service as a whole," the Surgeon General wrote, "that we regard this assignment as a serious challenge . . . I am asking our regional medical officers to offer their assistance to you in developing such medical and health civil defense plans as are required in your State. I want also to assure you that the facilities of our staff in Washington are available to you to the limit of our capacities."

Dr. Scheele emphasized that "our thinking and planning these days must go well beyond the usual components of peacetime programs. In addition to protection of water and food supplies, sanitation, and industrial health services, we must think, as well, in terms of mass casualty services and of defense against biological, radiological, and chemical warfare. We must think in terms of potential disasters far beyond our national experience. Our planning must, therefore, match in imagination and scope the greatest potential damage which could be inflicted on us by a determined enemy."

Incidence of Disease

No health department, State or local, can effectively prevent or control disease without knowledge of when, where, and under what conditions cases are occurring

UNITED STATES

Reports From States for Week Ended January 6, 1951

Measles. For the current week 5,364 new cases of measles were reported as compared with 4,101 for the previous week. The 5-year (1946–50) median for the first week is 3,044.

Other diseases. There was an increase in the number of cases of whooping cough for the current week, 1,573, as compared with 1,387 for the previous week. Meningococcal meningitis increased from 78 for the week ended December 30 to 96 for the current week. Poliomyelitis cases decreased in number, 136 being reported for the week ended January 6. The total number of influenza cases reported was 1,849 for the current week.

Reports of Epidemics

Gastroenteritis. In separate reports, Dr. R. M. Albrecht, New York State Department of Health, and Dr. J. C. Hart, Connecticut

Comparative Data for Cases of Specified Reportable Diseases: United States

[Numbers after diseases are International List numbers, 1948 revision]

Disease	Total For Week Ended—		5-year median 1946–50	Seasonal low week	Cumulative Total Since Seasonal Low Week		5-year median 1945–46 through 1949–50
	Jan. 6, 1951	Jan. 7, 1950			1950–51	1949–50	
Anthrax (062)	1	-------	(1)	(1)	(1)	(1)	(1)
Diphtheria (055)	121	166	258	27th	3,028	4,437	6,616
Encephalitis, acute infectious (082)	7	13	6	(1)	(1)	(1)	(1)
Influenza (480–483)	1,849	4,077	4,136	30th	40,256	34,607	40,406
Measles (085)	5,364	3,044	3,044	35th	34,053	22,174	28,893
Meningitis, meningococcal (057.0)	96	73	83	37th	1,057	986	986
Pneumonia (490–493)	1,675	2,210	-------	(1)	(1)	(1)	(1)
Poliomyelitis, acute (080)	136	124	79	11th	[2]32,356	41,576	24,876
Rocky Mountain spotted fever (104)	-------	1	1	(1)	(1)	(1)	(1)
Scarlet fever (050)	[3]1,455	1,232	2,007	32d	[4]17,146	17,671	24,551
Smallpox (084)	1	1	3	35th	9	8	25
Tularemia (059)	10	24	37	(1)	(1)	(1)	(1)
Typhoid and paratyphoid fever (040, 041) [5]	28	26	38	11th	2,943	3,399	3,454
Whooping cough (056)	1,573	1,660	1,660	39th	23,175	23,196	26,083

[1] Not computed. [2] Addition: Maryland, delayed report, 7 cases. [3] Including cases reported as streptococcal sore throat. [4] Addition: Utah, week ended December 30, 37 cases. [5] Including cases reported as salmonellosis.

State Department of Health, reported the occurrence of gastroenteritis in several groups of individuals following the ingestion of headcheese purchased from a single establishment in East Port Chester, Conn. This headcheese had been supplied by a meat market located in Brooklyn, N. Y.

On December 20, 1950, six cases occurred in Port Chester and Harrison, Westchester County, N. Y.: three women from Port Chester who lunched together that day, another woman in Port Chester, and an adult couple in Harrison. Eighteen individuals, residents of Greenwich, Conn., were affected following a party. The incubation period varied between 3 and 6 hours.

Samples of the headcheese were cultured at the Greenwich City Public Health Laboratory which revealed a profuse growth of staphylococci and *B. coli*. An employee of the establishment from which the headcheese was purchased is reported to have had diarrhea 2 to 3 days before the onset of the outbreak. The investigation is being continued to determine more accurately the source of infection.

Dr. A. L. Gray, Mississippi State Board of Health, has reported an outbreak of "food poisoning" on December 16, 1950, at a dinner party given by an industrial firm in a hotel in Jackson, Miss. Of the 150 people attending the dinner, 44 were affected with sudden onset of severe cramping, diarrhea, vomiting, muscle pains, and prostration. The incubation period ranged from 1 to 14 hours with a median of 7½ hours. It was impossible to determine the exact cause or source of the outbreak. No food was available for bacteriological examination. Sanitation of the premises and handling of food were excellent. Hotel employees who ate food remaining from the dinner were not ill.

Laboratory Supplement

Laboratory confirmation has been received of a case of psittacosis in Chicago. The person affected was a woman who worked in a pet shop, where there were several sick parrots, prior to the onset of her illness on November 22, 1950. A complement fixation test on the patient's blood was negative in the acute stage of the disease and positive (1-32) on December 22. These tests were confirmed by the Illinois State Health Department Laboratory.

Reported Cases of Selected Communicable Diseases: United States, Week Ended Jan. 6, 1951

[Numbers under diseases are International List numbers, 1948 revision]

Area	Diphtheria (055)	Encephalitis, infectious (082)	Influenza (480–483)	Measles (085)	Meningitis, meningococcal (057.0)	Pneumonia (490–493)	Poliomyelitis (080)
United States	**121**	**7**	**1,849**	**5,364**	**96**	**1,675**	**136**
New England	**4**		**2**	**211**	**3**	**64**	**4**
Maine	2			2	1	13	1
New Hampshire			1			1	
Vermont				90	1		
Massachusetts	2			106			1
Rhode Island				5			
Connecticut			1	8	1	50	2
Middle Atlantic	**6**	**1**	**7**	**951**	**20**	**182**	**31**
New York	4	1	[1] 1	394	4	68	23
New Jersey			6	115	3	55	3
Pennsylvania	2			442	13	59	5
East North Central	**11**	**2**	**84**	**1,287**	**14**	**128**	**3**
Ohio	6			308	6		
Indiana			24	46	1	12	2
Illinois	5	2	1	273	6	76	1
Michigan			1	190		10	
Wisconsin			58	470	1	30	
West North Central	**10**		**12**	**578**	**6**	**132**	**9**
Minnesota	2			69	2	2	1
Iowa				3	1	1	1
Missouri	5			196	1		
North Dakota			12	5		123	2
South Dakota	1			21			3
Nebraska	2						1
Kansas				284	2	6	1
South Atlantic	**28**	**1**	**786**	**295**	**22**	**386**	**16**
Delaware				2			
Maryland			3	5	2	28	2
District of Columbia			1	15		25	
Virginia	3		511	157	3	127	2
West Virginia	3		202	15	1	13	2
North Carolina	9			47	4		5
South Carolina	4		35	9		22	
Georgia	7	1	34	42	6	171	3
Florida	2			3	6		2
East South Central	**29**	**1**	**54**	**232**	**9**	**59**	**12**
Kentucky	2		6	133	3	22	
Tennessee	6		32	50	4		6
Alabama	14	1		3	1		3
Mississippi	7		16	46	1	37	3
West South Central	**28**	**1**	**577**	**829**	**13**	**588**	**19**
Arkansas	6	1	363	162	2	44	1
Louisiana	1		2	3		41	4
Oklahoma	4		212	111	4	32	1
Texas	17			553	7	471	13
Mountain	**1**	**1**	**324**	**343**	**2**	**107**	**9**
Montana			31	7		8	1
Idaho			20			6	1
Wyoming				7	1	1	1
Colorado		1	7	206		53	2
New Mexico	1			6		7	2
Arizona			266	58		32	
Utah				52	1		2
Nevada				7			
Pacific	**4**		**3**	**638**	**7**	**29**	**33**
Washington	1			281		3	5
Oregon			3	21		26	5
California	3			336	7		23
Alaska							1
Hawaii			2	2			

[1] New York City only.
Anthrax: New York, 1 case.

Reported Cases of Selected Communicable Diseases: United States, Week Ended Jan. 6, 1951—Continued

[Numbers under diseases are International List numbers, 1948 revision

Area	Rocky Mountain spotted fever (104)	Scarlet fever (050)	Smallpox (084)	Tularemia (059)	Typhoid and paratyphoid fever [1] (040, 041)	Whooping cough (056)	Rabies in animals
United States		**1,455**	1	**10**	**28**	**1,573**	**127**
New England		**183**			**1**	**293**	
Maine		19				55	
New Hampshire		18				14	
Vermont		7			1	76	
Massachusetts		123				83	
Rhode Island		3				52	
Connecticut		13				13	
Middle Atlantic		**216**			**2**	**253**	**28**
New York		[2] 118				111	22
New Jersey		40				74	
Pennsylvania		58			2	68	6
East North Central		**322**			**3**	**211**	**11**
Ohio		72			1	30	6
Indiana		37				25	3
Illinois		59			1	20	2
Michigan		128			1	68	
Wisconsin		26				68	
West North Central		**100**				**44**	**10**
Minnesota		23				16	2
Iowa		12				1	6
Missouri		32				7	
North Dakota		1				9	
South Dakota		1					
Nebraska		5					
Kansas		26				11	2
South Atlantic		**197**		**5**	**8**	**266**	**14**
Delaware						2	
Maryland		16				14	
District of Columbia		6					
Virginia		41		3	5	129	1
West Virginia		9		1	2	42	
North Carolina		83				40	
South Carolina		16			1	4	10
Georgia		12				27	3
Florida		[2] 14		1		8	
East South Central		**109**		**3**	**4**	**63**	**23**
Kentucky		29		2		15	11
Tennessee		52		1	2	19	6
Alabama		19			1	26	3
Mississippi		9			1	3	3
West South Central		**93**		**1**	**7**	**219**	**36**
Arkansas		8			2	14	
Louisiana		1			1	2	1
Oklahoma		17		1		18	1
Texas		67			4	185	34
Mountain		**73**	**1**	**1**	**3**	**173**	**1**
Montana		5				21	
Idaho		5				4	
Wyoming		1				1	
Colorado		17				38	
New Mexico					2	25	
Arizona		7			1	84	1
Utah		[2] 38		1			
Nevada			1				
Pacific		**162**				**51**	**4**
Washington		62				25	
Oregon		29				1	
California		[2] 71				25	4
Alaska						1	
Hawaii		2					

[1] Including cases reported as salmonellosis.

[2] Including cases reported as streptococcal sore throat.

FOREIGN REPORTS

CANADA

Reported Cases of Certain Diseases—Week Ended Dec. 16, 1950

Disease	Newfoundland	Prince Edward Island	Nova Scotia	New Brunswick	Quebec	Ontario	Manitoba	Saskatchewan	Alberta	British Columbia	Total
Brucellosis					1						1
Chickenpox	3		32	1	383	355	49	96	105	155	1,179
Diphtheria					5	1		1			7
Dysentery, bacillary					2	5				3	10
Encephalitis, infectious					1						1
German measles				3	17	51		11	25	108	215
Influenza			34				1				35
Measles	4		9		393	962	59	14	14	60	1,515
Meningitis, meningococcal					1		1				2
Mumps	7		27		230	337	41	128	241	199	1,210
Poliomyelitis					1			1		2	4
Scarlet fever	2			2	93	34	9	19	55	54	268
Tuberculosis (all forms)	5		5	3	54	15	10	11	2	55	160
Typhoid and paratyphoid fever					23			1		1	25
Venereal diseases:											
Gonorrhea	6		21	2	47	57	26	11	25	63	258
Syphilis	1		7	3	29	26	2	16	1	10	95
Primary					1	3					4
Secondary				3	1	5					9
Other	1		7		27	18	2	16	1	10	82
Whooping cough	3		4	6	126	112	26	1	7	13	298

NORWAY

Reported Cases of Certain Diseases—October 1950

Disease	Cases	Disease	Cases
Diphtheria	48	Paratyphoid fever	2
Dysentery, unspecified	1	Pneumonia (all forms)	2,691
Encephalitis, infectious	1	Poliomyelitis	246
Erysipelas	401	Rheumatic fever	81
Gastroenteritis	2,861	Scabies	1,124
Hepatitis, infectious	66	Scarlet fever	156
Impetigo contagiosa	2,440	Tuberculosis (all forms)	314
Influenza	6,728	Typhoid fever	1
Malaria	2	Venereal diseases:	
Measles	413	Gonorrhea	192
Meningitis, meningococcal	8	Syphilis	67
Mumps	56	Whooping cough	1,922

WORLD DISTRIBUTION OF CHOLERA, PLAGUE, SMALLPOX, TYPHUS FEVER, AND YELLOW FEVER

The following tables are not complete or final for the list of countries included or for the figures given. Since many of the figures are from weekly reports, the accumulated totals are for approximate dates.

CHOLERA

(Cases)

Place	January–October 1950	November 1950	December 1950—week ended—				
			2	9	16	23	30
ASIA							
Burma	538	531	208	178	.....	4	9
Akyab	2	.....	.....	.....	.....	.....	.....
Bassein	3	.....	.....	.....	.....	4	9
Kyaukpyu	2	.....	.....	.....	.....	.....	.....
Maubin	3	.....	.....	.....	.....	.....	.....
Moulmein	1	.....	.....	.....	.....	.....	.....
Pegu	1	.....	.....	.....	.....	.....	.....
Rangoon	6	[1] 1	.....	.....	.....	.....	.....
Toungoo	8	.....	.....	.....	.....	.....	.....
India	137,021	17,555	[2] 1,621	[2] 184	[2] 61	[2] 85	[2] 106
Ahmedabad	10	.....	.....	.....	.....	.....	.....
Allahabad	3	.....	.....	.....	.....	.....	.....
Bombay	[3] 430	.....	.....	.....	[1] 1	.....	.....
Calcutta	9,162	173	25	17	18	59	68
Cawnpore	1	.....	.....	.....	.....	.....	.....
Coconada	2	.....	.....	.....	.....	.....	.....
Cuddalore	51	8	.....	.....	.....	1	.....
Lucknow	12	.....	.....	.....	.....	.....	.....
Madras	[3] 885	144	33	33	14	.....	15
Masulipatam	47	.....	.....	.....	.....	.....	.....
Nagpur	71	.....	.....	.....	.....	[1] 7	.....
Negapatam	98	19	3	3	9	9	8
New Delhi	125	.....	.....	.....	.....	.....	.....
Port Blair (Andaman Islands)	[1] 2	.....	.....	.....	.....	.....	.....
Tellicherry	27	.....	.....	.....	.....	.....	.....
Tiruchirappali	1	23	4	1	1	9	11
Trichinopoly	1	.....	.....	.....	.....	.....	.....
Tuticorin	26	.....	.....	15	18	.....	4
India (French)	1,172	45	8	25	21	.....	.....
Karikal	405	36	6	15	15	.....	.....
Pondicherry	767	9	2	10	6	.....	.....
India (Portuguese)	17	.....	.....	.....	.....	.....	.....
Indochina:							
Cambodia	9	6	.....	.....	.....	.....	.....
Viet Nam	15	.....	.....	.....	.....	.....	.....
Giadinh	3	.....	.....	.....	.....	.....	.....
Rachgia	1	.....	.....	.....	.....	.....	.....
Saigon	1	.....	.....	.....	.....	.....	.....
Pakistan	24,505	1,559	650	[2] 171	[2] 253	[2] 1	.....
Chittagong	186	.....	.....	.....	.....	.....	.....
Dacca	192	3	.....	3	2	1	.....

[1] Imported. [2] Preliminary. [3] Includes imported cases.

PLAGUE

(Cases)

AFRICA							
Belgian Congo	31	.....	.....	.....	.....	.....	.....
Costermansville Province	15	.....	.....	.....	.....	.....	.....
Stanleyville Province	16	.....	.....	.....	.....	.....	.....
Madagascar	76	29	.....	4	.....	.....	.....
Rhodesia, Northern	2	.....	.....	.....	.....	.....	.....
Union of South Africa	17	.....	.....	.....	.....	.....	.....
Cape Province	3	.....	.....	.....	.....	.....	.....
Orange Free State	11	.....	.....	.....	.....	.....	.....
Transvaal Province	1	.....	.....	.....	.....	.....	.....
Johannesburg	1	.....	.....	.....	.....	.....	.....
ASIA							
Burma	254	19	1	.....	.....	.....	.....
Bassein	1	.....	.....	.....	.....	.....	.....
Bhamo	[1] 4	.....	.....	.....	.....	.....	.....
Henzada	15	.....	.....	.....	.....	.....	.....

Place	January–October 1950	November 1950	December 1950—week ended— 2	9	16	23	30
ASIA—continued							
Burma—Continued							
Kyaiklat	34						
Minhla	2						
Moulmein	[1] 3						
Myaungmya	5						
Myingyan	2						
Pegu	[1] 5						
Prome	[2] 1						
Pyapon	3						
Rangoon	[1] 8						
Yenangyaung	58						
China:							
Chekiang Province	42						
Wenchow	[3] 4						
Fukien Province	988						
Amoy	10						
Kwangsi Province	[3] 63						
Kwangtung Province	627						
India	40, 217	1, 315	[4] 78	[4] 108	[4] 1		
Allahabad	[2] 19				[2] 1		
Bombay	[1] 5						
Calcutta	[1] 3						
Cawnpore	18						
Lucknow	[1] 10						
Indochina:							
Cambodia	[5] 46						
Pnompenh	3						
Viet Nam	121	11	2			1	1
Phanthiet	91	3				1	1
Saigon	1						
Laos	2						
Indonesia:							
Java	423			[6] 176			
Bandoeng	6						
Djakarta	3						
Jogjakarta	234			[6] 176			
Pakistan	[2] 1						
Karachi	[2] 1						
Thailand	56						
SOUTH AMERICA							
Brazil	40	10					
Alagoas State	11	6					
Bahia State	12	3					
Ceara State	2						
Paraiba State	5						
Pernambuco State	9	1					
Sao Paulo State: Santos	1						
Ecuador	27						
Chimborazo Province	4						
El Oro Province	4						
Loja Province	19						
Peru	28						
Ancash Department	3						
Lambayeque Department	2						
Libertad Department	1						
Lima Department	11						
Piura Department	11						
Venezuela	5						
Miranda State	5						

[1] Includes imported cases. [2] Imported. [3] Deaths. [4] Preliminary figure. [5] Includes suspected cases. [6] Nov. 12 to Dec. 9, 1950.

SMALLPOX

(Cases; P = Present)

AFRICA							
Algeria	108	7					
Angola	270						
Bechuanaland	168						
Belgian Congo	4, 114	423	102	53	97		
British East Africa:							
Kenya	12						

Place	January–October 1950	November 1950	December 1950—week ended— 2	9	16	23	30
AFRICA—continued							
British East Africa—Continued							
Nyasaland	265	17	3				
Tanganyika	4,520	50					
Uganda	3	1					
Cameroon (British)	437						
Cameroon (French)	126	7					
Dahomey	403	14		[1] 4		[2] 68	
Egypt	[3] 6						
Eritrea	1						
Ethiopia	36						
French Equatorial Africa	454						
French Guinea	12						
French West Africa: Haute Volta	217	13		[1] 4			
Gambia	5	1					
Gold Coast	254	6	3	28	13		
Ivory Coast	[4] 652	12		[1] 2		[2] 20	
Libya	2						
Mauritania	1						
Morocco (French)	10	5					
Mozambique	319	21					
Nigeria	17,257	283					
Niger Territory	1,135	84		[1] 9			
Rhodesia:							
Northern	5						
Southern	703						
Senegal	2						
Sierra Leone	32						
Sudan (Anglo-Egyptian)	76	4	2	1			
Sudan (French)	226	75		[1] 17			
Togo (French)	105	16		[1] 1			
Tunisia	1						
Union of South Africa	900	14	P	P			
ASIA							
Afghanistan	390	140					
Arabia	336						
Bahrein Islands: Bahrein	36						
Kamaran Island: Kamaran	[5] 2						
Burma	5,051	6	1	4	18	2	
Ceylon	[3] 2	1					
China	777	7				1	
India	126,090	5,786	[6] 1,426	[6] 936	[6] 345	[6] 354	[6] 368
India (French)	474	118	34	32	30		
India (Portuguese)	101						
Indochina	332	7	11	10	2		2
Cambodia	89			6			
Viet Nam	243	7	11	4	2		2
Indonesia:							
Borneo	1,065	201	50				
Java	7,538	118	1	27	19	2	
Sumatra	346						
Iran	305	68	13	18	6	21	10
Iraq	[3] 184	36	9	9	5	6	23
Israel	16						
Japan	6						
Korea (Republic of)	1,331						
Lebanon	[3] 2						
Netherlands New Guinea	3						
Pakistan	16,530	1,173	451	[6] 211	[6] 292	[6] 9	
Palestine	95						
Straits Settlements:							
Singapore	[3] 2						
Syria	15						
Thailand	460						
Transjordan	35						
Turkey. (*See* Turkey in Europe.)							
EUROPE							
Great Britain:							
England: Liverpool	[5] 1						
Scotland: Glasgow	21						
Greece	15						
Portugal	1						
Spain: Canary Islands	1						
Turkey	8						

See footnotes at end of table.

Place	January–October 1950	November 1950	December 1950—week ended— 2	9	16	23	30
NORTH AMERICA							
Guatemala	8						
Mexico	506						
SOUTH AMERICA							
Argentina	517						
Brazil	98	13					
Chile	3,588						
Colombia	600	2					
Ecuador	197	40					
Paraguay	4						
Peru	2,680						
Venezuela	1,538						
OCEANIA							
Australia: Freemantle	[5] 1						

[1] Dec. 1–10, 1950. [3] Includes imported cases. [5] Imported.
[2] Dec. 11–20, 1950. [4] Corrected figure. [6] Preliminary.

TYPHUS FEVER*

(Cases: P=present)

AFRICA							
Algeria	109	3					
Basutoland	24						
Belgian Congo	[1] 90						
British East Africa:							
Kenya	23						
Mombasa	[2] 3						
Uganda	2						
Egypt	89	3		1	1		
Eritrea	32	3		1			
Ethiopia	1,046						
French Equatorial Africa	5						
Gold Coast	10						
Libya:							
Cyrenaica	27						
Tripolitania	71						
Madagascar	2						
Morocco (French)	10						
Morocco (International Zone)	2						
Morocco (Spanish Zone)	6						
Mozambique	3						
Nigeria	1						
Rhodesia, Southern	[1] 7						
Sierra Leone	[2] 5						
Sudan (Anglo-Egyptian)	5						
Tunisia	59						
Union of South Africa	98	P	P	P			
ASIA							
Afghanistan	1,303						
Burma	[1] 15						
Ceylon	1	1					
China	[1] 20						
India	318	3	3	4	1		1
India (Portuguese)	57	19					
Indochina: Viet Nam	34		1				
Indonesia:							
Java	6						
Sumatra	1						
Iran	[1] 204	6	1	1			
Iraq	131		2			3	
Japan	[1] 927	1	2				
Korea (Republic of)	[2] 1,161						
Lebanon	[1] 2						
Netherlands New Guinea	2						
Pakistan	99	3	1				
Palestine	7						
Straits Settlements: Singapore	[1] 8						
Syria	[1] 39						
Transjordan	28						
Turkey (see Turkey in Europe):							

Place	January–October 1950	November 1950	December 1950—week ended— 2	9	16	23	30
EUROPE							
France	1						
Germany (British Zone)	[1] 2						
Germany (French Zone)	2						
Germany (United States Zone)	3						
Great Britain:							
England: **Liverpool**	[2] [3] 1						
Island of Malta [1]	35	5					
Greece	28						
Hungary	4						
Italy	52						
Sicily	41						
Poland	37						
Portugal	2	3					
Spain	47						
Turkey	174	19	1	6	11	11	5
Yugoslavia	257	7					
NORTH AMERICA							
Costa Rica [1]	17						
Guatemala	32						
Jamaica [1]	30	1	1				
Mexico [1]	344	5					
Panama Canal Zone [1]	6						
Puerto Rico [1]	18	1					
Virgin Islands	1						
SOUTH AMERICA							
Argentina	2						
Chile	128	6	3		6		
Colombia	511	4					
Curacao	3						
Ecuador	297	51					
Peru	1,089						
Venezuela	133						
OCEANIA							
Australia [1]	103	1					
Hawaii Territory [1]	6	2					

*Reports from some areas are probably murine type, while others include both murine and louse-borne types.

[1] Includes murine type. [2] Murine. [3] Imported.

YELLOW FEVER

(C—cases; D—deaths)

Place		January–October 1950	November 1950	December 1950—week ended— 2	9	16	23	30
AFRICA								
Belgian Congo	C	1		1				
Stanleyville Province	C	1		1				
French Equatorial Africa	C	[1] 1						
Port Gentil	C	[1] 1						
Gold Coast	C	16	2					
Accra	D	[2] 4						
Ankobra Ferry	D	1						
Bogoso	C	[2] 2						
Kade	C	1						
Oda Area:								
Akwatia	C	[2] 7	[1] 1					
Atiankama	C	1						
Taquah-Aboso	D		[1] 1					
Nigeria	D	[2] 2						
Calabar	D	[3] 1						
Ibadan	D	[1] 1						
Sierra Leone	C	[2] 2						
Koinadugu District	C	[2] 2						
NORTH AMERICA								
Panama:								
Colon	D	1						

See footnotes at end of table.

Place		January–October 1950	November 1950	December 1950—week ended—				
				2	9	16	23	30
SOUTH AMERICA								
Bolivia	C	867						
Chuquisaca Department	C	[4] 850						
La Paz Department	C	[5] 17						
Brazil	D	2						
Bahia State	D	1						
Ipiau	D	1						
Maranhao State	D	1						
Colinas	D	1						
Colombia	D	5	3					
Boyaca Department	D		1					
Chizu	D		1					
Magdalena Department	D	1						
Los Angeles, Rio de Oro	D	1						
North Santander Department	D	1						
Ocana	D	1						
Putumayo Commissary	D	3						
Mocoa Locality	D	3						
Santander Department	D		2					
Cuesta Rica	D		1					
Landazuri	D		1					
Peru	D	14						
Cuzco Department	D	2						
Quincemil	D	2						
Huanuco Department	D	6						
Tingo Maria	D	6						
Junin Department	D	1						
San Ramon	D	1						
Loredo Department	D	1						
Puealpa	D	1						
San Martin Department	D	4						
Bellavista	D	1						
Juanjui	D	1						
Lamas	D	1						
Tarapoto	D	1						
Venezuela	D	2	1					
Bolivar State	D	2						
Argelia	D	1						
La Parida	D	1						
Tachira State	D		1					
El Milagro	D		1					

[1] Suspected. [2] Includes suspected cases. [3] Imported. [4] Estimated number of cases reported in an outbreak in Asero Province Jan. 1–Mar. 14, 1950. [5] Outbreak in North and South Youngas Provinces.

Influenza Outbreaks Under Continuing Observation

Background

In 1947 the Federal Security Agency and the Department of Defense established a Nation-wide program to study and exchange information about influenza. This program has been conducted by a large number of laboratories collaborating with the Surgeons General of the Public Health Service, the Army, the Navy, and the Air Force.

This is part of a world-wide program sponsored by the World Health Organization to study influenza and to aid health authorities and physicians to control the disease. The World Influenza Center is located in London, England. The United States Influenza Information Center is located at the National Institutes of Health of the Public Health Service in Bethesda, Md. The Center serves as headquarters in this country for collecting and disseminating information concerning influenza throughout the world.

The Outbreak in England

The Information Center has been following carefully the influenza situation in England. It appears that the current outbreak started in late December in the northern part of the country, centering around Liverpool. It has increased gradually to the proportions of a sizeable and serious epidemic involving rather large numbers of people. Information received thus far indicates that the epidemic involves northern England mainly, and has not yet spread in any considerable degree to Scotland or southern England.

The substantial increase in deaths from influenza has occurred chiefly among the aged and infirm. For others the character of the disease has in general not been too severe. The type of influenza appears to resemble that which has been encountered frequently in local outbreaks in this country for the past several years.

Spread From Sweden

From London, the World Influenza Center at the National Institute for Medical Research reported as follows early in January:

"As a not unexpected sequel of the local outbreak of influenza A-prime in Sweden in June 1950, the disease appeared in Scandanavia early this winter, in Denmark in November, in northern Sweden and Norway in late November, and in Sweden generally in December. The Danish strain is an A-prime, apparently identical with that occurring in Sweden in June.

"Late in December, influenza appeared in northern England where a mild form seems to be widespread. Serological evidence suggests that it is type A, but the virus has not yet been isolated. The beginning of the outbreak around Newcastle suggests likelihood of importation from Scandanavia.

"Since Scandanavia and Britain had a low incidence in 1949, while much of the rest of western Europe had much more, it is possible that the reverse will be true this winter and that continental western Europe apart from Scandanavia will suffer but only lightly. Other reports of influenza this year are from Sardinia, Iran, and northern Spain, but no details are available."

The National Office of Vital Statistics of the Public Health Service had not received (as of January 19) mortality data from official sources in England on which fatality rates could be based.

U. S. Advisory Committee Statement

On January 18 the Advisory Committee for the United States in the World Health Organization's influenza study program met at Bethesda in one of its regular meetings.[1] The day following the meeting, Surgeon General Leonard A. Scheele of the Public Health Service telegraphed the 10 regional directors of the Federal Security Agency as follows:

"Localized epidemics of influenza occur at this season in the United States every year. Only occasionally do these localized epidemics become widespread. None has had the characteristics of the 1918 pandemic of influenza. At this time there is no reason to believe that the present epidemic in England necessarily indicates that there will be a serious or widespread epidemic in the United States this year.

"The question of immunization against this outbreak or any outbreak of influenza is not settled. There is no vaccine that we can expect will protect with certainty. However, this situation indicates the necessity for continuing controlled studies of the efficacy of influenza vaccine in man. It is expected that some influenza will appear in the United States but that the disease will be like our recent experiences with influenza.

"Since the greatest part of the mortality results from bacterial

[1] The membership of the Advisory Committee is as follows: For the Surgeon General of the Public Health Service, Dr. Norman Topping (chairman); for the Surgeon General of the Army, Col. Don Longfellow; for the Surgeon General of the Navy, Capt. R. W. Babione; and for the Surgeon General of the Air Force, Maj. L. C. Kossuth. Representing the special regional laboratories (seven in the United States, one in Canada, and one in Puerto Rico) were: Dr. M. F. Schaeffer, Communicable Disease Center of the Public Health Service, Montgomery, Ala.; Dr. E. H. Lennette, California State Board of Health, Berkeley; Dr. A. P. McKee, University of Iowa, Iowa City; Dr. Maxwell Finland, Boston City Hospital, Boston, Mass.; Dr. Irving Gordon, New York State Department of Health, Albany. Also participating in the discussion were Dr. Dorland J. Davis, director of the National Influenza Information Center, Bethesda, Md.; Dr. T. P. McGill, director of the Influenza Strain Study Center, Brooklyn, N. Y.; and Dr. C. C. Dauer, medical advisor, National Office of Vital Statistics, Public Health Service, Washington, D. C.

complications in the respiratory tract, it is recommended that (for patients who have a severe influenza-like illness) appropriate antibiotics be used."

U. S. Clinical and Laboratory Studies

Scientists from the Public Health Service and laboratories in New York are studying cases of influenza found among persons arriving by ship from England. Other collaborating organizations are also studying the problem.

Type A in London

A cable from the world Influenza Center on January 17 advised that influenza type A virus had been isolated from current cases occurring in London. On January 18, specimens were received by air from London. These are being distributed to appropriate laboratories by the Influenza Strain Study Center in Brooklyn, N. Y. The Strain Study Center operates under the Armed Forces Epidemiologic Board Commission on Influenza, of which Dr. Thomas Francis, Jr., is chairman. The Strain Study Center investigates newly isolated strains of virus for their antigenic characteristics in an effort to discover strains of influenza virus which have superior immunizing potentialities.

Type A in Spain and Japan

The Weekly Epidemiological Record of the WHO for January 10, 1951, reports that an outbreak due to influenza virus type A in Spain has been confirmed by laboratory examination. An epidemic of influenza has been reported in Japan, principally in the southern part during the early part of December 1950. Laboratory examinations have confirmed the presence of type A virus in Fukouka prefecture, Yamanashi, and Tokyo.